Issue Briefs:

Massachusetts

Behavioral Health Analysis

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Recovery and Peer Support

Since the 1999 Surgeon General's report,[1] the fields of mental health and substance abuse treatment have been transformed by a new focus on promoting and sustaining recovery. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[2] While many disabling behavioral health conditions may require some level of illness self-management and recovery support, recovery is attainable. Sustaining recovery from substance abuse problems is also a significant focus for individuals who have experienced them.

Peers, people who have experience in coping with and recovering from mental illnesses and substance abuse, are in a unique position because of their personal experience to provide health literacy and help others manage their symptoms, and develop hope for the future .[3] Recovery support services are increasingly being funded on a limited basis nationally, and in Massachusetts, by public behavioral health agencies. They are being used for the treatment of chronic diseases[4] and recommended as an important part of the continuum of services in overall health system.[5] Two recent reviews published by SAMHSA[6] summarize the research for peer support services:

- For people with mental illness,[7] a majority of studies comparing usual care to either peers that supplement usual care or peers delivering curricula on their own found that use of peers had better outcomes. Compared with professional staff, there was some evidence that the use of peers led to reduced inpatient utilization and improved a range of recovery outcomes. In virtually all cases, consumers preferred the support of peers to usual care.
- For people with substance use disorders,[8] peer support approaches demonstrated reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.

Numerous states have recognized certified peer support services as a Medicaid reimbursable service. As of 2012, certification standards have been proposed and adopted in 36 states including

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1 U.S. Department of Health and Human Services. (1999). Mental health: A report of the Surgeon General. *Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health*.

2 http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/#.U7aRTPldWa8

3 Solomon, P. (2004). Peer support/peer provided services underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal 27* (4), 392.

4 Heisler, M. (2006). Building peer support programs to manage chronic disease: Seven models for success. *California Health Care Foundation.*

5 Reif, S. et al. (2014). Peer recovery support for individuals with substance use disorders: Assessing the evidence. *Psychiatric Services*, *65* (7).

6 Ibid

7 Chinman, M., et al. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, *vol. 65*, no 4.

8 Reif, S., et al. (2014). Op. Cit.

Massachusetts.[9] In 1999, Georgia was the first state in the country to obtain Medicaid funding for peer support and the program has been so successful that in 2007, the Centers for Medicare and Medicaid Services (CMS) urged other states to do the same and sent out guidelines.[10] Advocates and others within Massachusetts have been urging adoption of peer support as a state plan service requiring formal certification, in addition to existing peer support services, such as the Family Partner services that are currently provided for families of youth with serious emotional disturbances through MassHealth managed care programs.

Nationally, efforts to develop peer recovery support for people with substance use disorders have lagged behind the mental health recovery movement in large part because so many states have limited benefits for substance abuse services. Peer support for substance abuse has grown out of Alcoholics Anonymous (AA) and related "mutual support" peer programs. These mutual support approaches demonstrated since 1935 differ from what we are calling peer support here because AA members provide mutual support rather than the "coaching" model promoted in peer recovery support programs. Since 2009, the SAMHSA Center for Substance Abuse Treatment has promoted the development of peer recovery support services and coaches through grants from the Recovery Community Services Program. Massachusetts funds seven Peer Recovery Support Centers across the state and funds the Recovery Coaches Academy which has trained and certified approximately 200 coaches.

As noted above, peers are increasingly recognized by CMS, SAMHSA, states, and many providers for their valuable contribution to the workforce as trained staff who can provide assistance in engaging consumers, and in some models, coordinating care. The literature also documents the value of peer supports for people with other chronic diseases in settings that include primary care offices, inpatient hospitals, housing programs, and others.[11] In these programs, peers function in roles similar to community health workers. As such, they are valuable and cost effective additions to a workforce of other licensed mental health and substance abuse clinicians.

[9] Kaufman, L., et al. (2012). Peer specialist training and certification programs: A national overview. *University of Texas at Austin Center for Social Work Research.*

[10] Centers for Medicare and Medicaid, State Medicaid Director's Letter #07-011, August 15, 2007.

[11] See for examples Heisler, M. (October 2007). Overview of peer support models to improve diabetes self-management and clinical outcomes. *Diabetes Spectrum*, *20* (4), 214-221.

Workforce Data Issues

It is well established that there is a current and projected national shortage of qualified behavioral health professionals.[12,13] However, the average rate of behavioral health professionals per population in Massachusetts is well above average. For instance, the Boston area has almost two and a half times the national average in psychiatrists per 100,000, leading the country in psychiatry and social workers per capita.[14] However, information about the number of licensed practitioners does not provide information about how much and where they are practicing.

The key mental health and substance abuse professional groups include Psychiatrists, Psychiatric Clinical Nurse Specialists, Psychologists, Social Workers, Licensed Mental Health Clinicians, Marriage and Family Therapists, and Licensed Alcohol and Drug Counselors. One potential way to enhance workforce data would be collect information from licensees at the time of license application and renewal. For purposes of health planning, the following data elements would be important:

- Work setting
- Location(s) of current practice
- Estimated weekly hours of practice (total and in each location if multiple locations)
- Payer mix

Additional information about languages spoken, race/ethnicity, gender, years of experience, and specialization might also be helpful.

One challenge to undertaking this data collection effort is the fact that several different boards manage licensure of the professionals listed above and each has its own data system. The Boards include:

- Board of Registration in Medicine – Psychiatrists
- Board of Registration in Nursing – Psychiatric Clinical Nurse Specialists
- Division of Professional Licensure (DPL) – There are separate Boards of Registration for Psychologists, Social Workers, and Allied Mental Health and Human Services Professionals (including Licensed Mental Health Clinicians, Marriage and Family Therapists, Rehabilitation Counselors, and Educational Psychologists). Applications are all in the same format.
- Department of Public Health (DPH), Bureau of Substance Abuse Services Quality Assurance and Licensing Unit – Licensed Alcohol and Drug Counselors.

[12] *An Action Plan for Behavioral Workforce Development*, The Annapolis Coalition on Behavioral Workforce Development, 2007. Retrieved 6/13/14 from http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf.

[13] Blue Cross Blue Shield of Massachusetts Foundation. (2009). Accessing children's mental health services in Massachusetts.

[14] Dartmouth Atlas of Healthcare, 2006 data. Retrieved from http://www.dartmouthatlas.org/data/table.aspx?ind=144&tf=8&ch=&loc=23,85&loct=3&addn=ind-144_tf-8&rus=1&fmt=169.

While the Boards differ in the type and amount of data collected, in general, licensure applications/renewals for these professions do not comprehensively collect the data fields described above. To improve data sources available to the Council for its future work, DPH plans to work with these boards to develop consensus on opportunities for enhanced data collection.

Integration of Behavioral Health and Primary Care

Many people have comorbid physical and behavioral health conditions and yet, until recently, the prevailing organization of our healthcare delivery system has separated behavioral health and primary care services. In Massachusetts, 17.1% of adults reported having a mental illness in the past year,[15] and the rate of mental illness was significantly higher (26.6%) among those who also had a physical health condition.[16] Similarly, 10.1% of MA adults reported substance dependence or abuse, and rates of substance use disorders were higher among those with more than one comorbid physical health condition (e.g., 13.1% of those with two comorbid health conditions, 14.0% of those with three or more).[17] Moreover, treatments for one type of disorder can exacerbate the other.[18] In general, having comorbid physical and behavioral health conditions is associated with a number of negative health outcomes, including functional impairment and decreased length and quality of life, as well as with increased health care costs.[19,20]

Despite the high prevalence of illness, relatively few physicians routinely screen for mental illness or substance use disorders. In 2006-2007 across the US, mental health screenings were conducted in only 2% of all physician office visits, although 79% of primary care practices offered mental health services onsite or by referral. [21] Across the country, many mental health and substance abuse providers are inadequately equipped to handle the increasingly complex physical health needs of their patients.[22] Indeed, both medical and mental health care providers face challenges in addressing patients' full spectrum of physical and behavioral health needs.

Care that integrates physical and behavioral health services can be an important part of the solution. Specifically, integrated care may increase the ability of medical providers to address behavioral health issues[23] and the ability of behavioral health providers to address medical issues,[24] as well as improve treatment outcomes for both mental health and substance use disorders. [25,26,27,28,29] Moreover, integrated care may have the potential to reduce healthcare costs. [30,31, 32]

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[15] SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey of Drug Use and Health, 2008-11 Combined and 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx.

[16] SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey on Drug Use and Health, 2008-2011 (revised 10/13). And 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx.

[17] SAMHSA, Center for Behavioral Health Statistics and Quality. *National Survey on Drug Use and Health, 2008-2011 (revised 10/13). And 2012.* Retrieved from http://www.samhsa.gov/data/NSDUH.aspx

[18] Druss, B. G., & Walker, E. R. (2011). Mental disorders and medical comorbidity. *Robert Wood Johnson Foundation, The Synthesis Project*. ISSN 2155-3718. Retrieved from www.policysynthesis.org

[19] Dickerson et al, 2008; Egede, 2007; Katon, 2003; Stein et al., 2006; as cited in Druss & Walker (2011)

[20] Commonwealth of Massachusetts, Health Policy Commission. (2014). 2013 Cost trends report: July 2014 supplement.

[21] HealthyPeople.gov. DATA2020. Retrieved from http://www.healthypeople.gov/

[22] Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services*, *61*, 1087-1092.

[23] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

[24] Druss & von Esenwein (2001), as cited in Druss & Mauer (2010).

[25] Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., & Lu, Y. (2001). Integrating primary medical care with addiction treatment: A randomized controlled trial. *Journal of the American Medical Association, 286*, 1715-23.

[26] Friedman, P. D., Shang, Z., Hendrickson, J., Stein, M. D., & Gerstein, D. R. (2003). Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *Journal of General Internal Medicine, 18*, 1-8.

There are a number of different approaches to the integration of medical and behavioral health care, including consultation between behavioral health and medical providers,[33] collaborative care involving a care manager and/or behavioral health consultant,[34] co-location of services, and partnerships between general health care providers and behavioral health care treatment providers.[35,36] Provider selection of integrated care models should consider the needs of the patient population being served. In particular, Cherokee Health Systems in Tennessee,[37] the DIAMOND Project in Minnesota,[38] and the Collaborative Care Model[39] are often cited as examples of effective integrated care.

At the practice level, integration takes two main forms: (1) expanding the capacity of primary care practices and health clinics to treat mental health and substance abuse diagnoses and (2) bringing better physical health care to people with serious mental illness or addictions served primarily through behavioral health providers. In primary care settings, collaborative care approaches (i.e., those that use a multidisciplinary team to screen and track behavioral health conditions) and adding a mental health clinician to a practice have enhanced primary care providers' ability to treat behavioral health conditions; patients experienced a higher quality of care, had better clinical outcomes, and were more satisfied with their care.[40,41,42,43]

Among populations with more intensive behavioral health needs being served in behavioral health settings, a number of components may facilitate integrated care: regular screening and tracking of glucose and lipid levels, blood pressure, and weight/BMI as well as care managers to support

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[27] Mauer, B. J. (2009 Apr). *Behavioral health/primary care integration and the person-centered healthcare home.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[28] Gilbody et al. (2006) as cited in Druss & Mauer (2010).

[29] Saitz et al. (2007) as cited in Druss & Mauer (2010).

[30] Milliman, Inc. (2014). *Economic impact of integrated medical-behavioral healthcare: Implications for Psychiatry*. Denver, CO: Melek, S. P., Norris, D. T, Paulus, J.

[31] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[32] Behavioral Health Integration Task Force. (2013). Report to the legislature and the health policy commission.

[33] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

[34] Mauer, B. J. (2009). *Behavioral health/primary care integration and the person-centered healthcare home.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[35] Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services, 61*, 1087-1092.

[36] Druss, B. G. & Walker, E. R. (2011). Mental disorders and medical comorbidity. Robert Wood Johnson Foundation, The Synthesis Project. ISSN 2155-3718. Retrieved from www.policysynthesis.org

[37] Accessed from http://www.cherokeehealth.com/

[38] Accessed from https://www.icsi.org/health_initiatives/mental_health/diamond_for_depression/

[39] Unützer, J., Harbin, H., Schoenbaum, M. & Druss, B. (2013). The Collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. *Health Home Information Resource Center Brief*. *Center for Health Care Strategies and Mathematica Policy Research.* Retrieved from http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf on 4/7/2014.

[40] Butler, et al. (2009) as cited in Druss & Walker (2011)

[41] Gilbody, et al. (2006) as cited in Druss & Walker (2011)

[42] Williams, et al. (2007) as cited in Druss & Walker (2011)

[43] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health*, *21*, 121-134.

individuals outside of the desired range; medical nurse practitioners and/or primary care physicians located in BH facilities or available for consultation; adapting evidence-based practices for medical conditions for use in the behavioral health system; and engagement of individuals in managing their health conditions, with peers serving as group facilitators.[44,45] Provision of primary care in methadone treatment settings was found to result in reductions in the number of emergency visits and acute hospitalizations for patients receiving both continuous methadone treatment and at least two primary care visits in comparison to other patients.[46]

Co-locating behavioral health and primary care services can greatly increase access to care.[47] Thus, integration will likely increase the capacity of both the medical and behavioral health systems to serve the needs of those with or at risk for comorbid physical and behavioral health conditions. The clinical integration of medical and behavioral health care must be a collaborative effort, supported by financing and infrastructure (including policy, licensure, regulation, workforce, and information sharing).[48]

To this end, many initiatives in the state are working to improve integration of behavioral health with primary care. Chapter 224 established a Behavioral Health Integration Task Force that developed a number of recommendations and actions to advance integration. In addition, MassHealth's Primary Care Payment Reform promotes integration of services, including through a capitated payment to primary care providers for primary care and some behavioral health services. Furthermore, the FY15 General Appropriations Act includes $2 million for a behavioral health integration initiative, administered by the Health Policy Commission. BSAS has also provided assistance to help providers enhance their ability to identify and address substance abuse issues among their patients by training staff to conduct screening, brief intervention, and referral to treatment (SBIRT). SBIRT is an evidence-based public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. BSAS provides technical assistance and training for the adoption of this model for hospital emergency rooms, school nurses, and other settings.

In addition, BSAS is working with the DPH Division of Health Quality to facilitate licensure of primary care clinics in substance abuse treatment settings and substance abuse clinic licenses in Federally Qualified Health Centers. Health information technology (e.g., electronic medical records)

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[44] Mauer, B. J. (2009 Apr). Behavioral health/primary care integration and the person-centered healthcare home. Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

[45] Commonwealth of Massachusetts, Health Policy Commission. (2014). 2013 Cost trends report: July 2014 supplement.

[46] Gourevitch, M. N., et al. (2007). On-site medical care in methadone maintenance: associations with health care use and expenditures on-site medical care in methadone maintenance: Associations with health care use and expenditures. *Journal of Substance Abuse Treatment, 32*, 2 143-51.

[47] Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems & Health, 21,* 121-134.

[48] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. *National Council for Community Behavioral Healthcare.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

may facilitate quality improvement and more integrated services,[49] and it will be important to balance confidentiality protections with the desire to ensure communication among providers for coordination of treatment goals and continuity of care. [50,51]

The Health Planning Council and the Commonwealth of Massachusetts have an extraordinary opportunity to increase the delivery of integrated care.

[49] Druss, B. G. & Mauer, B. J. (2010). Health care reform and care at the behavioral health-primary care interface. *Psychiatric Services*, *61,* 1087-1092.

[50] Shortell, et al. (2000) as cited in Druss & Mauer (2010)

[51] Mauer, B. J. (2009). Behavioral health/primary care integration and the person-centered healthcare home. *National Council for Community Behavioral Healthcare.* Retrieved from http://www.allhealth.org/briefingmaterials/BehavioralHealthandPrimaryCareIntegrationandthePerson-CenteredHealthcareHome-1547.pdf

Mental Health Parity and Addiction Equity Act

Changes made by recent federal health care laws are generating a profound change in the behavioral health system. The Mental Health Parity and Addiction Equity Act (MHPAEA), passed in 2008, requires that both fully insured and self-insured large group health plans that cover mental health and substance use disorder benefits do so in a way that is no more restrictive than for physical health (i.e., medical/surgical) benefits. The ACA expanded the application of MHPAEA to plans in the individual and small employer markets and required that these plans provide ten essential health benefits, including mental health and substance use disorder treatment. Because the plans must offer MH and SUD coverage, they must do so at parity with their physical health benefits. In addition, the ACA applied the MHPAEA to Medicare Advantage plans offered through group health plans, state and local government plans, Medicaid managed care plans, and State Children's Health Insurance Plans.

Parity means that the financial requirements and non-quantitative treatment limitations for behavioral health services cannot be more restrictive than those for substantially all medical/surgical services.[52] Since behavioral health services do not always correspond to medical/surgical services, understanding how to determine comparability has been complicated. However, the final regulations for MHPAEA, issued in November 2013, have set standards clarifying a number of questions that arose after the interim regulations were issued.

There are six benefit classifications within which plans may not impose a financial requirement or treatment limit restriction for behavioral health services that is more restrictive than the predominant requirement or restriction applicable to substantially all medical/surgical benefits. The benefit classifications are: (1) outpatient in-network services, (2) outpatient out-of-network services, (3) inpatient in-network services, (4) inpatient out-of-network services, (5) emergency care, and (6) prescription drugs.[53] The regulations define predominant as more than half, and substantially all as at least two-thirds. The final regulations allow insurers to define behavioral health services that fall between inpatient and outpatient (e.g., non-hospital residential treatment, partial hospitalization, intensive outpatient) as either inpatient or outpatient, as long as they do so consistently for similar medical/surgical services.[54] In addition, the regulations provide guidance on how to apply these rules. The final regulations also specify that any non-quantitative treatment limitations, including those stemming from medical management standards, prescription formulary design, standards for inclusion in provider networks, and determination of provider rates of reimbursement are subject to MHPAEA. A number of examples of compliant and noncompliant NQTLs are discussed.

[52] Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services. (2011). The mental health parity and addiction equity act. Retrieved from: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html#main_content

[53] Departments of the Treasury, Labor, and Health and Human Services. (2013, November 13). Final rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act 2008. *Federal Register, 78,* no. 219, accessed from http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf on July 7, 2014.

[54] RAND Corporation. (2012). Short-term analysis to support mental health and substance use disorder parity implementation.

State insurance commissioners (the Division of Insurance in Massachusetts) are responsible for enforcement in the group and individual insured health plan markets of their state, [55] and MHPAEA does not supersede states laws that are more stringent. The federal Departments of Labor and Treasury have shared jurisdiction over private, employment-based group health plans, and Health and Human Services (HHS) oversees non-federal governmental plans, such as those sponsored by state and local government employers.

Within Massachusetts, regulations require insurance carriers to assess their compliance with state[56] and federal parity laws and regulations annually and submit a certificate of compliance to the Division of Insurance[57] and the Attorney General.[58] Medicaid contracted managed care plans must review their administrative and other practices and submit a report on their review and to either certify that their plans fully comply with the federal and state mental health parity laws, or identify areas of non-compliance and a corrective action plan to bring those practices into compliance (Add footnote to 130 CMR 450.117(J)).

Research on the impact of the implementation of parity requirements has generally not found an increase in expenditures. One review found that the implementation of parity requirements was associated with reduced expenditures in six out of nine studies.[59] A separate study examining the effects of parity on expenditures for behavioral health services in Oregon suggests that parity does not substantially influence total costs.[60] Overall, evidence indicates that parity will not dramatically increase enrollee expenditures. It is still unclear what effect parity will have on access to and utilization of behavioral health care; in a review of 17 studies examining the effect of coverage on access to or use of behavioral health services, findings were mixed.[61]

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[55] Weber, E. (2013). Equality standards for health insurance coverage: Will the Mental Health Parity and Addiction Equity Act end the discrimination? *Golden Gate University Law Review, 43*, 179-257.

[56] Chapter 256 of the Acts of 2008, An Act Relative to Mental Health Parity accessed from https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter256 on July 7, 2014.

[57] 211 CMR 15 4.00: Enforcement of Mental Health Parity accessed from http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-154-proposed.pdf on July 7, 2014.

[58] Chapter 224 An act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation. Section 254, accessed from https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224 on July 7, 2014.

Health Information Technology

Health information systems originated in claims and billing systems, followed shortly by electronic enrollment systems. Beginning in the 1980s, SAMHSA's Data Infrastructure program began to fund client treatment episode data systems in states, including Massachusetts. Doctors, hospitals, and other providers have developed and implemented Electronic Health Records (EHRs) to track clinical information and link it to claims. However, adoption of health information technology by behavioral health providers lags behind other sectors of the health care system. The Massachusetts eHealth Institute (MeHI) recently conducted a survey that found an adoption rate of 96% among primary care providers and 86% among specialty providers but only 55% for behavioral health providers.[62] Historically, many behavioral health providers have not been eligible for Medicare and Medicaid EHR incentive programs. Chapter 224 of the Acts of 2012 sought to address this gap by provided funding to assist these providers with EHR adoption. In addition to incentives, there are several other factors that affect health information technology in behavioral health:

1. The slow development of behavioral health applications by vendors;
2. Different payment and documentation requirements across states and among different payers;
3. The small size and the many different types of behavioral health programs and providers;
4. The need of many behavioral health providers for financial resources for technology investment;
5. Privacy concerns by behavioral health providers as well as patients may also play a role in the delay in implementing behavioral health treatment notes in an EHR or sharing such data through a health information exchange;
6. Differing or complex patient consent laws governing the electronic exchange of information related to substance abuse may confuse behavioral health providers and cause them to shy away from implementing electronic health records altogether.

The federal Health Insurance Portability and Accountability Act (HIPAA) provided a framework for data exchanges among payers and between providers to support treatment, payment, and operations. However, there are special privacy protections afforded to alcohol and drug abuse patient records, such as those in delineated in regulations at 42 CFR Part 2. Some worry that the exchange of behavioral health data is overly hindered by these protections, while others maintain that these protections appropriately balance confidentiality concerns with the need to exchange necessary health care information. SAMHSA has recently held a listening session on the 42 CFR Part 2 regulations.[63]

There are also special considerations pertaining to data collected and maintained by DMH and BSAS. Much of the behavioral health system for those with the most serious conditions and special populations is funded by DMH and BSAS, whose funding and data systems differ markedly from the claims based systems of health insurers. BSAS and DMH data are not part of the APCD. Both agencies

[63] SAMHSA opens door to weakening 42 CFR part 2. (2014, June 16). *Alcoholism and Drug Abuse Weekly, 26,* (4). Retrieved from http://patientprivacyrights.org/wp-content/uploads/2014/06/ADAW-June-16-2014.pdf

currently use the Commonwealth's Enterprise Invoice and Enterprise Service Management System (EIM/ESM). These two systems use a common web-based interface for invoice payment and service reporting. EIM/ESM provides licensed and contracted programs with the ability to submit encounter, assessment, and billing data for clients in treatment for substance abuse. Reports in EIM/ESM provide operational information concerning enrollment, billing, and payment status for both agencies.

For BSAS, the EIM/ESM data from encounter and bill processing are forwarded monthly to the BSAS Data Mart for reporting and analytics. However, there are some limitations with the billing data. The BSAS Data Mart environment supports the evaluation of individual client outcomes and provider program performance for those receiving or potentially needing substance abuse treatment services. Primary (EIM/ESM and SAMIS) and secondary (CHIA Hospital and Vital Registry) data sets are combined in the Data Mart, using client linking, enrollment or admission consolidation and other algorithms to create the most accurate longitudinal profile of clients possible.

DMH also uses EIM/ESM for payment of claims and can produce some client level reports. DMH also supports multiple data systems, including its electronic health record, the Mental Health Information System (MHIS) which manages enrollment data for all DMH clients. DMH links MHIS enrollment data with data reported by providers and several other datasets in the DMH Data Warehouse. Greater use in the future of client level data, including EIM/ESM data, coupled with increasing use of claims for unit rates supporting service payment (e.g. clubhouses), will allow DMH to enhance its data infrastructure.

The Center for Medicare and Medicaid Innovation (CMMI) is providing funding via a State Innovation Model grant to primary care providers and their behavioral health partners to assist both entities with the exchange of secure, electronic patient information. This funding is intended to help primary care providers and their behavioral health partners use the Mass HIway, operated by the Massachusetts' Executive Office of Health and Human Services, to exchange electronic patient information.

The Commonwealth is working both to advance adoption of health information technology by behavioral health providers and to strengthen its own data systems and analytics. This inaugural health planning effort has both demonstrated the value of cross-payer analytics, and identified areas where improvements to data systems are needed to more readily facilitate analysis.

Payment Reforms

Historically, health care services have been paid for on a fee-for-service basis. However, there is an increasing recognition that a fee-for-service system tends to reward the volume of care delivered, rather than value. With rising health care costs, policymakers and purchasers have looked to payment reform to better align payment incentives with the "Triple Aim" of improving population health, patient experience of care, and reducing per capita costs).[64]

Nationally, the Affordable Care Act (ACA) created a number of special initiatives focused on payment and delivery system reform. These programs have included the Medicare Shared Savings Program, the Pioneer ACO program, integrated care demonstrations for dual eligible individuals, bundled payments, and initiatives to strengthen primary care. Many states are also pursuing Accountable Care Organization models within their Medicaid programs.

Massachusetts' cost containment law, Chapter 224 of the Acts of 2012, similarly supports the adoption of alternative payment methodologies. Chapter 224 includes requirements for public payers (including MassHealth and the Group Insurance Commission) to adopt alternative payments, and establishes certification programs for Patient Centered Medical Homes and Accountable Care Organizations. Massachusetts also received a State Innovation Model grant from the federal government to promote the adoption of alternative payment methodologies.

Within MassHealth, Primary Care Payment Reform has implemented an innovative payment model that promotes integration of primary care and behavioral health services, with a capitated payment for primary care and some behavioral health services. This initiative builds on the Patient Centered Medical Home Initiative which combined a payment model of infrastructure support and shared savings with a robust technical assistance program. MassHealth also partnered with CMS to develop and implement One Care, the first demonstration integrating care for dual eligible individuals to launch nationally. Through One Care, MassHealth and Medicare make global payments to health plans contracted to provide comprehensive care management and integrated medical, behavioral health, and long term services and supports benefits to adults with disabilities.

The shift to alternative payment methodologies engenders some considerations specific to behavioral health. For one thing, new models may or may not include behavioral health in their payment model, such as in the calculation of total cost of care. For example, while some state ACO models include behavioral health expenditures as part of the calculation of total cost of care (against which shared savings/shared risk is measured), not all states do. In addition, global or capitated payments to providers need to be adequately risk adjusted to account for the cost of providing care to high-cost populations, and the methodologies need to be robust when applied to high behavioral health need populations. Furthermore, because many of these alternative payment methodologies focus on the quality of care provided and the outcomes of populations, there need to be an adequate array of validated measures to assess the quality of behavioral health care that is provided and to ensure that

[64] Rosenthal, M., et al. (2007). Employers' use of value-based purchasing strategies. *JAMA*, *298* (19), 2281-2288. doi:10.1001/jama.298.19.2281

the incentives to contain costs are not resulting in inappropriate service reductions. The availability of data and the capacity to analyze data relating to population costs and management will be important, and this type of data and capacity may lag in the behavioral health space, for some of the reasons described in the Issue Brief on Health Information Technology.

As payments shift from purchasing volume to purchasing value, it will be important to carefully monitor the impact of such payment models on the behavioral health care system.